



THE PRIORITIES OF VICTORIAN RURAL CONSUMERS WHO TRAVEL FOR HEALTHCARE

Loddon Mallee Roundtable
Swan Hill, Victoria

24 April 2009

10.00 am - 4.00 pm

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INTRODUCTION

This report brings together the reflections and ideas generated by consumers and health care workers from the Loddon Mallee region in Victoria and Melbourne who discussed '*The needs of Victorian consumers who travel for healthcare*' and worked together to consider and define solutions and strategies to the key issues.

HIC learnt from the experience of the earlier roundtable held in Gippsland, in December 2008 of the value of having positive practice examples from Melbourne and regionally, as well as having a more directed focus for the discussion between participants.

The needs of consumer who travel for healthcare are complex and multifaceted. The roundtable in Loddon Mallee focused on **health service communication and coordination with each other and with rural consumers** to better provide access and care throughout people's long journeys for healthcare.

The objectives of the roundtable were:

- ▶ To bring together key primary and acute health services and organisations involved in healthcare and transport support to Loddon Mallee health consumers and communities, as well as regional consumers and community members involved in health matters and development
- ▶ To provide an opportunity for discussion on regional priorities and sustainable actions on travel and support needs of Loddon Mallee health consumers and communities
- ▶ To develop key action follow-up – affirming existing initiatives and identifying new possibilities within and across services and organisations

The Reference group supporting HIC in the development of the regional roundtables also recommended contact with Country Health South Australia who have developed and implemented the Patient Journey Initiative. HIC saw this connection as opportune given that many consumers in the Loddon Mallee region access health services in South Australia. We were grateful that Karen Dixon, Coordinator of the Patient Journey initiative could attend and share insights based on their direct practice.

The regional roundtables were a follow-up action to the discussion paper prepared by HIC in 2008 with a focus on 'The Needs of rural consumers who travel to Melbourne Hospitals.' The paper can be downloaded at <http://www.healthissuescentre.org.au/documents/items/2008/10/233648-upload-00001.pdf>

HIC has chosen to document the complete ideas developed at the roundtable because we believe they give clear direction to the Department of Human Services and to health services both in Melbourne and in rural Victoria, as to the priorities of action that need to be taken up to better provide supportive and coordinated healthcare for rural consumers who travel for healthcare.

INDIGENOUS ACKNOWLEDGMENT

Health Issues Centre would like to acknowledge the traditional custodians of the land on which we meet and pay our respects to elders both past and present. In acknowledging the traditional custodians we reinforce our commitment to reconciliation and the part we all play in addressing the gap in health inequality that currently exists in our Indigenous communities.

PROCEEDINGS

1. Attendance and process

36 people attended the roundtable including representatives from primary and public health services, state government, Divisions of General Practice, Primary Care partnerships, community groups and individual consumers.

A full-list of the participants and their organisations is included in Appendix 2.

The session was facilitated by Jackie Mansourian, Senior Project Officer, Health Issues Centre and Panayiota Romios, Deputy CEO, Health Issues Centre. HIC would like to acknowledge the clear insights and processes shared by Karen Dixon, Coordinator Patient Journey and Out of Hospital Strategy, Country Health SA, in the development of the agenda and process.

2. Presentations

Three excellent presentations began the workshop and the discussion. There is a lot we can learn from all these excellent initiatives at the different levels.

2.1 Learnings and possibilities for Victoria, Patient Journey Initiative, Country Health, South Australia; Karen Dixon, Coordinator Patient Journey and Out of Hospital Strategy

2.2 A city hospital initiative for rural consumers, Accommodation Liaison Officer role at St. Vincent's Hospital, Melbourne; David Hine RN Clinical Coordinator HDM Cluster & Nurse Unit Manager, MediHotel & Treatment Centre

2.3 Local Initiative - The Gannawarra Non-Emergency Transport Service (G -NETS); Anne Graham, Director of Nursing, Cohuna District Hospital

See Appendix 1 for summary of each presentation.

3. Discussion

In table discussions, participants focused on the issues and the strategies and solutions for each of the four key transition points in the journey of rural consumers.

1. Pre-journey issues
2. At the hospital (regional or metropolitan)
3. Going home and linking with services @ home
4. Follow-up issues

Participants considered the issues and concerns from the perspective of consumers at each of these key points in the journey of rural consumers for health care.

They also developed very clear solutions and strategies at the systemic level and at the level of primary and public health services. These are recorded below in the section on Findings.

HIC encourages careful reading of the section on Findings.

Pre-Journey Issues for consumers travelling for healthcare

What communication and coordination needs to happen before a person leaves home?

Issues from consumers' perspective	How can they be addressed? Solutions? Who can fix it?
<p>1. Where are we going? – Address/phone/contact numbers</p> <p>2. Who am I seeing?</p> <p>3. Where will I stay?</p> <p>4. How will I get there? Who is reminding me to fill in the VPTAS forms?</p> <p>5. Is there a contact person when I get there?</p> <p>6. If my appointment is cancelled, how and when will I find out?</p> <p>7. Knowing implications of treatment change</p> <p>8. What do I have to take with me e.g. test result/x-rays?</p> <p>9. Can my family/support person stay with me? (Can I go if I am carer?)</p> <p>10. How long will I be there?</p> <p>11. Worrying about support in Melbourne.</p> <p>12. Is there public transport available when I get to the city?</p>	<p>Rural GP services:</p> <p>The GP practice is the key point of information and coordination for rural consumers/patients. This could mean a role re-design for GP practice managers/nurses. Refer to systemic processes/developments.</p> <p>To support this changing role and for rural GP services to be able to consistently coordinate and provide information to rural patients they need:</p> <p>i) Centralised/internet based resources/information to include access to:</p> <ul style="list-style-type: none"> • accommodation list accessible to referring health service (Note: Mallee Division of General Practice Accommodation Guide and St Vincent's as examples) • VPTAS forms • different local transport alternatives and support – these include HACC funding, VPTAS, fuel vouchers?, Local Transport Connections project, public transport • contacts with other appropriate support organisations e.g. Financial assistance from Salvation Army and St Vincent's <p>ii) Checklist to give to consumers 'The questions to ask when you go to see specialist/or regional/city hospital'. iii) Direct contact in regional/metro hospital - social worker or rural liaison worker in hospital. iv) Immediate reminder to GP/Nurse within data base of required information to give to patient when they need to travel v) List of visiting specialists and waiting lists for each which can be easily assessed (as in NSW).</p> <p>Changing/strengthening coordination practices of rural GP services to include:</p> <p>i) Identifying rural patients In the referral form, from GP to specialist, there needs to be in the header/a flag a way of quickly identifying/saying this is a rural patient, please accommodate their special needs(for example, appointment timing). ii) Provide all information identified in 2, including travel, accommodation, key contact person iii) GP to ensure that s/he has provided patient with results of tests iv) Encourage patient/consumer to use checklist of questions in communication with hospital</p> <p>Specialist/regional/city hospitals Hospitals also have responsibility before the patient leaves home:</p> <p>i) The hospital which people are being referred to need to provide a clear point of contact for rural consumers – social worker and or rural liaison worker?</p>

Pre-Journey Issues for consumers travelling for healthcare cont....

What communication and coordination needs to happen before a person leaves home?

Issues from consumers' perspective	How can they be addressed? Solutions? Who can fix it?
<p>13. If going by car, what parking is available?</p> <p>14. Feeling confused and anxious about going being unwell and going to 'city'.</p> <p>15. How much is it going to cost me?</p> <p>16. What are they going to do to me?</p> <p>17. Knowing and being communicated with about impending status of care and requirements</p> <p>18. Who will do what I normally do and who will look after my children? (farming)</p> <p>19. Worrying about being away from home.</p>	<p>ii) Hospitals to consider defining rural liaison position as position who can coordinate and advocate f for rural consumers/patients.</p> <p>iii) Have a prepared package of information which answers the key questions patients/consumers will have – about outpatients/preadmission/specific procedures/parking or public transport/accommodation for patients and carer.</p> <p>iv) Special provision of information about transport in town/city, including timetable of different public transport alternatives for people arriving in Melbourne, VPTAS, Travellers' Aid services.</p> <p>v) Inform patient should appointment details or treatment change (mobile phone contact).</p> <p>Other Transport Considerations Cross government solutions to transport i.e. Ageing, Disability and Acute – Investing \$\$ to local communities to determine a local solution to transport issues i.e. public \$ for transport.</p> <p>Developing support and solutions locally for rural people travelling for healthcare</p> <p>i) Community Reference point Local community centre/ social worker to link and provide support through family/friendship network.</p> <p>ii) Local government coordination of social support networks for family/children who are staying at home while caregiver goes for treatment away.</p>
	<p>Systemic/overarching including DHS</p> <p>i) Clear government commitment and directive for coordinated and holistic response to rural consumer access and support across continuum of healthcare. Initiative and follow-up needs to come from DHS statewide in collaboration with regional offices.</p> <p>ii) Need of a centralised resource for health services for coordinated referrals and information about diverse services available locally, regionally and Melbourne. One possibility already exists in www.connectingcare and needs further development and support</p> <p>iii) Need for business case for GPs to consider the changing role of practice managers/nurses as key providers of information, support and coordination to patients who have to travel for healthcare</p> <p>iv) Effective communication for whole-of-transport alternatives and travel support available e.g. engaging local community organisations and using audio-visual communication about VPTAS using TV screens in GP waiting rooms.</p>

At the hospital (regional or city)

What communication and coordination needs to happen when a person arrives at regional/city hospital?

Issues from consumers' perspective

How can they be addressed? Solutions? Who can fix it?

1. Who is the contact person?
2. Finding my way around the hospital.
3. Which entrance do I use?
4. Do they know I'm a country person?
5. Parking – a big issue for volunteer drivers of community transport as well as carers/patients.
6. Do they have my records/pre-admission notification etc?
7. Are the two hospitals communicating with each other?
8. Does my family know where I will be?
9. Will appointments be consecutive/timely if needed?
10. Will there be a place for my family/partner/carer to stay if necessary?
11. Where do I eat, if I have to wait?
12. How long will I need to wait?

Rural GP services:

- i) Affirm the important role of GP service to directly link rural patient/consumer with key contact in hospital - either social worker or rural patient liaison officer?
 - Communication between GP and hospital before admission is essential, including pre-admission, referral

Specialist /regional/city hospitals

- i) Identifying rural consumers readily and consistently
 - Referral forms should have a clear way of identifying rural consumers
 - For inpatients – a 'map' to identify country patient in ward/bed
- ii) Coordinating and advocacy role – a rural liaison worker or social worker?
 - To guide the patient and family within the system of the hospital
 - To support the patient/carer with understanding the information/alternatives available, including transport/accommodation
 - To advocate for 'rurality' to be a prime consideration in the procedures and decisions in:
 - Coordination of appointments(at least in timing of outpatients appointments)
 - Ongoing information to patient during treatment taking place
 - Discharge and coordination between rural consumer, GP, local hospital and other local services prior to 'transfer of care'.
- iii) Development and timely availability of information package to rural consumer before they leave home with various details including travel, transport, parking, eating at the hospital and accommodation
- iv) Good signage at the hospital.
- v) Development and availability of current accommodation guide/costs etc accessible to hospital.
- vi) St Vincent's model of an accommodation officer and accommodation guide on website useful. It needs to be implemented in other hospitals and communicated effectively in regions/rural health services.
- vii) Parking
 - Exemption to country patients e.g. disability stickers
 - Designated area of pickup and drop off that works. Longer times are needed so volunteer drivers can assist
- viii) Training for front-line staff of the importance of keeping the patient informed.

At the hospital (regional or city) cont...

What communication and coordination needs to happen when a person arrives at regional/city hospital?

Issues from consumers' perspective

How can they be addressed? Solutions? Who can fix it?

13. Will I be in a room with someone else?

14. Will I be informed along the way?
Where will the family stay?
How far from the hospital?

15. Will my GP and others be kept up to date?
(Lack of coordination between services and providers)

16. What forms will I need to fill out and will there be assistance to do this?

Systemic/overarching changes including DHS

- i) DHS to promote establishment and integration of a way of identifying rural patients across the continuum of health care services
 - Rural gold card? Flags?
- ii) Additional (DHS) funding as well as internal health service prioritisation of development of role of rural liaison and ongoing communication and coordination. Learn from the rural patient liaison network in South Australia.
- iii) Fund travel subsidy for transport and accommodation through Medicare – in recognition that there is an unbalance in claims between metro and rural consumers (rural people make comparatively less Medicare claims). All patients must have an address for Medicare purposes and all provider numbers are location specific.
- iv) For travel subsidy from VPTAS (DHS). Better to have a rebate on kms travelled than to limit over 100kms.

Going Home and Linking with services @ home

What communication and coordination needs to happen when a person is returning home after treatment at a regional/city hospital?

Issues from consumers' perspective	How can they be addressed? Solutions? Who can fix it?
<p>1. All people discharged need a safe place to go.</p> <p>2. Who is at home? – carer availability? – family dynamics?</p> <p>3. Financial circumstances: Recognise poverty and economic burden of rural people, employment, workers' compensation issues?</p> <p>4. How am I going to get home? Public; private; ambulance – air or road (travel subsidy)</p> <p>5. What support will I need at home?</p> <p>6. What services am I going to need? Where will they be? What medication?</p> <p>7. Carer support and knowledge of care and complications which can occur.</p> <p>8. Linkages with other service providers and follow-up: – DNS; OTS; GP, rural hospital, allied health, local visiting specialists</p>	<p><i>Rural GP services</i></p> <p>Key point of communication and coordination by referring hospital.</p> <p><i>Specialist /regional/city hospitals</i></p> <p>i) Holistic assessment and approach towards rural patient to be discharged, including psychosocial health and understanding of what support mechanisms already available.</p> <p>ii) Decision and process of early planning of discharge to be done with carer/family/patient. Communication needed several days prior to them leaving hospital.</p> <p>iii) Having a clear system of identifying rural patients (e.g. map over inpatient bed) which can then trigger <i>early</i> communication with locally based services prior to transfer.</p> <p>iv) Use www.connectingcare.com as place for referral and coordination with locally based services.</p> <p>v) Carers, as family members should have 24 hour links made locally in case of difficulties.</p> <p>vi) Transport decisions by health services needs to match health needs. Transport needs to consider family members /carers involved. Poverty of rural residents needs to be considered.</p> <p>vii) Discharge with extra medications that takes into consideration travel/unavailability locally - at least 7 days and avoid later week discharge unless planned/coordinated locally and with family/carer.</p> <p>viii) Communication must be linked back to the locally based care i.e. mental health nurses, GP, allied health.</p> <p>ix) Language accessible and culturally appropriate information and support to patient and family on their return home, about self-care and ongoing follow-up with local services.</p> <p><i>District and rural health services</i></p> <p>i) Key contact/care coordinator based at rural hospitals who can be key point of contact for regional/city hospitals and coordinate ongoing care and support locally.</p> <p><i>Systemic/overarching changes including DHS</i></p> <p>i) Government leadership to review and reconceptualise discharge towards 'transfer of care ' – new way of thinking about discharge for both referring and receiving health services. This to include:</p> <ul style="list-style-type: none"> • connection between local health services and community services from hospital. • the role of 'discharge coordinators' from hospital to hospital or from hospital to home (is it the same position as rural patient liaison?) • Use of common communication (encrypted IT), maximise IT possibilities.

Going Home and Linking with services @ home cont...

What communication and coordination needs to happen when a person is returning home after treatment at a regional/city hospital?

Issues from consumers' perspective	How can they be addressed? Solutions? Who can fix it?
	<ul style="list-style-type: none">ii) Bring together all existing all care coordinators in specific areas of healthcare and develop an ongoing network for continuum of care initiatives.iii) Training of medical practitioners to include experience as a rural patient/client; experience distanceiv) Integration into practice of patient-centred care along the whole continuum of care, and for rural patient who have travelled this is especially significant at the key transition points, when leaving home and when returning home.

Follow up and care from home

What communication and coordination needs to happen when a person has returned home with ongoing care needs?

Issues from consumers' perspective	How can they be addressed? Solutions? Who can fix it?
<p>1. Do they or others know if they have a case manager and who/where they are?</p> <p>2. Access to services</p> <ul style="list-style-type: none"> - How will I get to services once home? - How do I find out what is going on? <p>3. How much is this going to cost?</p> <p>4. Who follows up and organises local appointments?</p>	<p><i>Rural GP services</i></p> <ul style="list-style-type: none"> i) Integral part of process of local coordination of care and support. ii) Anticipate referral for allied health assessment for possible home modifications as part of ongoing communication with hospital during treatment. <p><i>Specialist /regional/city hospitals</i></p> <ul style="list-style-type: none"> i) Notification of discharge from discharging hospital to GP/ regional/rural health services/allied health. ii) Coordinate with closest available health service to deliver ongoing care <ul style="list-style-type: none"> • Organise phone consultation between specialists/ GP/patient/carer iii) Ensure that support for carer and patient is clear and in place. <ul style="list-style-type: none"> • Be aware that support differs across different shires. • Contact numbers on fridge magnets? iv) Outpatient visits could happen more locally (e.g. regional and or district health services) <ul style="list-style-type: none"> • Hospital/specialist from referring hospital to realistically assess if person needs to return to city hospital. <p><i>Systemic/overarching changes including DHS</i></p> <ul style="list-style-type: none"> i) Government leadership and policies in place to include coordination care across whole continuum of journey from moment GP refers rural patient for healthcare where they travel to at home care home after treatment. <ul style="list-style-type: none"> • Infrastructures e.g. Reference group for development of liaison coordination ii) Extra \$\$ for rural services, especially allied health.

ADVOCATING FOR CHANGE

A whole group discussion developed reflecting on the future and how to keep the momentum going for the clear actions identified at the roundtable:

- ▶ PCP Networks in the regions are important for service planning and coordination – we need to report back to them and for them to take on and continue process.
- ▶ Lobby our politicians based in the regions.
- ▶ We need to give feedback to all our organisations represented here - share the learnings and ideas that have arisen from the roundtable.
- ▶ Have more consumers at such forums to enable their experiences and ideas to be part of the discussion.
- ▶ CACs to use the discussion to put/keep it on the agenda of their health services.
- ▶ Utilise various existing forums/coordinated meetings to present/discuss these ideas.
 - Divisions of General Practice (Quarterly forum); DHS Quality Managers (Quarterly forum)
- ▶ What is the status of the initial discussion paper and recommendations? Needs clarifying
- ▶ This discussion has been about a whole systemic response to the needs of rural consumers who travel – not just about transport and accommodation – we need to keep it at this level but then how/who takes it forward?
- ▶ Recognise that there are lots of small networks of coordinated care already happening and build on those relationships for a more holistic and integrated approach to coordination across the continuum of care e.g. post-acute care, social workers, Aboriginal Liaison workers. The question is – do all these smaller existing networks add up to a whole?

HIC will take these considerations for ongoing advocacy as part of future work.

IN APPRECIATION

HIC thanked the presenters for the presentation of their stimulating initiatives and all the participants, and in particular those who had travelled from within the vast region of Loddon Mallee, and contributed with commitment and effort.

APPENDIX 1: SUMMARY OF PRESENTATIONS

Three excellent presentations began the workshop and the discussion. There is a lot we can learn from all these excellent initiatives at the different levels.

The following are key points made by each of the presenters.

Learnings and possibilities for Victoria, Patient Journey Initiative, Country Health South Australia, Karen Dixon, Coordinator Patient Journey and Out of Hospital Strategy

Key Issues for Action identified by South Australia Patient Journey Initiative

Key Issue 1	Referral systems and processes between country health services and between country and Adelaide-based health services
Key Issue 2	Transport, accommodation and carer support services
Key Issue 3	Discharge planning from Adelaide hospitals back to Country SA
Key Issue 4	The Patient Journey for particular groups of people from Country SA
Key Issue 5	Avoiding unnecessary journeys through strategies such as appropriate use of telemedicine
Key Issue 6	Availability of health services in country locations
Key Issue 7	Informing consumers and carers

Karen focused on the action in the development of the Rural Liaison position in health services and the Patient Liaison Network.

Rural liaison position

Well documented benefits of a liaison role

- Better coordination of transfer of care
- Facilitate a smooth transition, linking points of care
- A central contact and coordinating point for services to contact
- Timely and accurate detailed referrals
- Improved understanding between service providers
- Improved patient outcomes

Country Health SA have funded some specific rural liaison positions, but many have been identified/established within and by health services.

Patient Liaison Network – Building a network of people to link the journey

Coordinating care

- reducing the need for travelling
- increasing skills and support
- proactively supporting people to move from metro and large regional centres back to home communities
- 180 health workers across country and metro S.A. supporting the country patient journey
- 94 nurses and allied health staff in country hospitals and in community health linked with rural
- Liaison/key nursing contacts at Metro Hospitals

2.2 A city hospital initiative for rural consumers, Accommodation Liaison Officer Role at St. Vincent's Hospital Melbourne, David Hine RN Clinical Coordinator HDM Cluster & Nurse Unit Manager, MediHotel & Treatment Centre

- Role established in 2004
- Position initially funded under DHS "Hospital Demand" strategy
- Initially limited to accommodating this patient cohort
- Role development to also assist patient relatives find accommodation
 - This was seen as a method to further enhance the discharge process for country patients
 - Qualified Social Worker ; Part time hours
 - Links with major external accommodation providers (about 100)
 - Negotiation of corporate rates with preferred providers

- Understanding of each provider's services
- Development of accommodation list of preferred providers. List continually reviewed in line with consumer feedback
- Modified psycho-social assessment on each referral to:
- Assess suitability of external accommodation option
 - Link patient with most suitable option; stairs; parking; Cost + ability to pay upfront fees; disabled facilities; distance from hospital; Refer back to inpatient bed/MediHotel if required

Website

www.svhm.org.au/infofor/visitors/accommodation.htm

**2.3 Local Initiative : Gannawarra Non-Emergency Transport Service (G -NETS),
Anne Graham, Director of Nursing , Cohuna District Hospital**

Key points

- It is very difficult for people who are aged, disabled or living with illness to attend health appointments in regional and/or city areas
- Many people do not have family to support them
- Non-emergency travel is now limited by Ambulance Victoria
- Some people simply cannot use public transport
- As a result the new Gannawarra Non-Emergency Transport Service (G-NETS) was developed and launched in September, 2008.

The new demand responsive bus service:

- is auspiced by the Cohuna District Hospital,
- is managed by a community steering committee,
- is coordinated by the Southern Mallee TCP, &
- is administered by 2 part-time clinical transport officers

The G-NETS:

- provides transport for people from their home to a
- regional/city health service and back again
- transports low acuity patients from hospitals & residential facilities to appointments in larger centres
- provides personal assistance during the journey & takes the worry out of long distance transport

The G-NETS also provides an important coordination role for people accessing health care, by:

- providing a link between referring agencies (such as medical centres) and clients
- arranging specialist medical & other allied health appointments
- liaising with clients and their carers/families in order to ensure
- that all travel/personal care needs are met
- promoting travel subsidies & assisting clients to access them
- attending specialist appointments with clients, as needed
- linking clients in with other services, as required &
- providing kindness and fellowship to people who are ill.

APPENDIX 2: LIST OF ATTENDEES

	FIRST NAME	LAST NAME	Position	ORGANISATION
1.	Sue	Armstrong	Coordinator	Woomelang Bush Nursing Service
2.	Gordon	Atkins	Community member	Swan Hill District Health, Regional HS Program
3.	Neva	Atkinson	Aboriginal Liaison Officer	Echuca Regional Health
4.	Lyn	Banks	Case Manager	Bendigo Health Case Management Services – Swan Hill
5.	Mary	Bowman	Community Member	Kyabram Health
6.	Liz	Brooks	Manager Public Health, Service Innovation	DHS Loddon Mallee
7.	Elaine	Carter	CEO	Northern District Community Health Services
8.	Bruce	Clare	Welfare Officer	Swan Hill District Health
9.	Sue	Clarke	CEO	Bendigo Community Health Services (part of the day)
10.	Jenny	Collins	PCP Service Coordination	DHS Loddon Mallee
11.	Bev	Cook	Community member	Health Consumers of Rural and Remote Australia
12.	Brenda	Fehring	Practice Capacity	Murray-Plains Division of GP
13.	Jackie	Forster	Senior Program Services Manager	Mallee Division of GP (part of the day)
14.	Anne	Graham	Director of Nursing	Cohuna District Hospital
15.	Judy	Greer	Board Member	Kyabram & District Hospital
16.	David	Hine	Clinical Coordinator HDM Inpatient Cluster & Nurse Unit Manager MediHotel, Treatment Centre	St Vincent's Hospital
17.	Casey	Kay	Youth Worker	Mallee Track Health and Community Services
18.	Nina	Kaylock	Community Member Community Advisory Committee	Swan Hill District Health
19.	Catherine	Kemp	Palliative Care Coordinator	Swan Hill District Health
20.	Gail	Kenyon	Practice Manager	Swan Hill Medical Centre
21.	Noel	King	Swan Hill Legacy & Community member	Swan Hill District Health
22.	Leanne	Mcfarlane		Southern Mallee Primary Care Partnership
23.	Cindy	Mcmillan	Administrative Officer	Sea Lake and District Health Service
24.	Judi	Maple		Swan Hill District Health

	FIRST NAME	LAST NAME	Position	ORGANISATION
25.	Tressna	Martin	Project Officer	Northern Mallee Transport Connections
26.	Trevor	Matheson	Director of Clinical Services	Mildura Base Hospital
27.	Vicki	Neitvelt		Bendigo Health - Case Management Services, Swan Hill
28.	Pamela	Oakley	HACC/Aged Care	DHS Loddon Mallee
29.	Margaret	Schindler	Community member Community Advisory Committee	Swan Hill District Health,
30.	David	Thompson	Executive Officer	Mallee Division of General Practice
31.	Paul	Smith	Executive Officer Primary Care Services	Swan Hill District Health
32.	Glenys	Smith		Loddon/Mallee Integrated Cancer Service Coordinator
33.	Denise	Smith	Project Officer	Southern Mallee Transport Connections
34.	Maree	Stringer	Day Centre Coordinator	Boort District Health

Apologies

	First Name	Last Name	Organisation
1.	Dane	Huxley	CEO, Mildura Base Hospital
2.	Ted	Rayment	CEO, Swan Hill District Health
3.	Ray	Tuhan	Rural Advocacy Project Reference Group
4.	Pauline	Venn	Rural Advocacy Project Reference Group
5.	Fiona	Watson	Director, Quality & Organisational Development, Peter MacCallum Cancer Centre
6.	Elena	Wilson	Consumer Liaison Officer, Bendigo Health
7.	Kate	Morrissey	Victoria Quality Council
8.	Roy	Hudson	Individual community member
9.	Paul	Banks	Volunteer, Kyabram Community Care
10.	Tanya	McPharlane	Outpatients Manager, Royal Victorian Eye and Ear Hospital